MINNESOTA LIFE

GROUP UNIVERSAL LIFE EMPLOYEE APPLICATION

Return form to: Minnesota Life Insurance Company • B2-4256 • 400 Robert Street North • St. Paul, Minnesota 55101-2098

EMPLOYER NAME: State of Delaware **POLICY NUMBER: 50166**

EMPLOYEE INFORMATION (employee is the owner of the insurance unless otherwise requested)

FIRST NAME	MIDDLE NAME/INITIAL	LAST NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTRY

E-MAIL ADDRESS (Optional)	DATE OF EMPLOYMENT

OCCUPATION	GENDER	HEIGHT	WEIGHT
	☐ MALE ☐ FEMALE		

If you are part-time, are you actively working at your employer's normal place of business at least 15 hours per week? ☐ Yes ☐ No
If you are full-time, are you actively working at your employer's normal place of business at least 30 hours per week? ☐ Yes ☐ No

BENEFICIARY DESIGNATION

PRIMARY BENEFICIARY'S NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENTAGE

CONTINGENT BENEFICIARY'S NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP	PERCENTAGE

INSURANCE INFORMATION

If applying for more than the guaranteed issue amount you must complete the **Health Questions** on the second page.

		Insurance Amount
(1)	Choose amount of Group Universal Life Insurance (multiples of salary):	☐ Waive all coverages including dependents. ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ 6x
(2)	Do you want to contribute to the cash accumulation account? ☐ Yes ☐ No	If yes, enter net pay amount (must be in whole dollars with a minimum of $5.00 per pay). $_____
(3)	Do you want to enroll your dependents for Dependent Term Life Insurance? ☐ Yes ☐ No	If yes, please choose option and complete information below. ☐ $10,000 Spouse only ☐ $10,000 Spouse and $6,000 Child(ren) ☐ $6,000 Child(ren)

DEPENDENT TERM LIFE INFORMATION

Please provide the following information for your eligible spouse and/or child(ren).

Dependent	Name	Date of Birth
☐ Spouse		
☐ Child		
☐ Child		
☐ Child		
☐ Child		
☐ Child		
☐ Child		
☐ Child		
☐ Child		
☐ Child		
☐ Child		

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CONSUMER PRIVACY NOTICE

In addition to the information requested on this application, the Company may ask for the following: an insurance medical exam or laboratory tests; medical records from your physician, hospital, or your insurance company; an investigative consumer report; a report from the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

The Company or its reinsurer may make a brief report of this information to the MIB. If you apply to another MIB member company for life or health insurance coverage, or claim for benefits is submitted to such company, the MIB, upon request, will supply such company with the information in its file. The Company may also send information about you to the following persons or organizations without your permission: to insurance organizations, for statistical studies, without identifying you; to a government agency involved in regulation of Insurance; to your physician (the results of your insurance exam). You have certain rights in connection with this insurance application. You have the right to: find out what personal information is contained in the Company or MIB files; correct or amend information in the Company or MIB files; know the specific reasons why coverage is not issued. At your request, the Company will explain in writing how you can exercise your right to learn what is in your file, how to correct or amend it, or how to find out why coverage is not issued.

For further information about your file or your rights, you may contact:
Group Division Underwriting
Minnesota Life Insurance Company
400 Robert Street North
St. Paul, Minnesota 55101-2098

For information about the Medical Information Bureau, you may contact:
Medical Information Bureau Information Office
P.O. Box 105, Essex Station
Boston, Massachusetts 02112
617-426-3660

HEALTH QUESTIONS

Please complete this section if you are applying for coverage above your existing or guaranteed coverage level.

☐ Yes ☐ No (1) During the past three years, have you for any reason consulted a physician(s) or other health care provider(s) or been hospitalized?

☐ Yes ☐ No (2) During the past ten years, have you ever had, or been treated for, any of the following: heart, lung, kidney, liver, nervous system, or mental disorder; high blood pressure; stroke; diabetes; cancer or tumor; drug or alcohol abuse including addiction?

☐ Yes ☐ No (3) Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), or any disorder of your immune system; or had any test showing evidence of antibodies to the AIDS virus (a positive HIV test)?

If you answer yes to any question, give particulars including dates, names and addresses of doctors or hospitals, the reason for the visit or consultation, the diagnosis, and the treatment in the Additional Health Information section below or on a separate sheet of paper.

ADDITIONAL HEALTH INFORMATION

DATE	NAME AND ADDRESS OF DOCTOR, CLINIC, HOSPITAL	REASON FOR CONSULTATION	DIAGNOSIS AND TREATMENT

The answers provided on this application are representations of the person signing below. The answers given are true and complete. It is understood that Minnesota Life Insurance Company (the Company), St. Paul, Minnesota 55101-2098 shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied.

To determine my insurability or for claim purposes, I authorize any person(s), medical practitioner, institution, insurance company or Medical Information Bureau (MIB) to give any medical or nonmedical information about me including alcohol or drug abuse, to the Company and its reinsurers. I authorize all said sources, except MIB, to give such information to any agency employed by the Company to collect and transmit such information. I understand in determining eligibility for insurance or benefits, this information may be made available to underwriting, claims, medical and support staff of the Company. This authorization is valid for 26 months. A photocopy shall be as valid as the original. I have read this and the Consumer Privacy Notice and I understand that I can have copies.

EMPLOYEE SIGNATURE	DAYTIME PHONE NUMBER	EVENING PHONE NUMBER	DATE SIGNED
X			

FOR HOME OFFICE USE ONLY:

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